0001

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
ALBANY DIVISION

MICHAEL NEWCOMB and KATHY NEWCOMB,	:	
Plaintiffs	:	CIVIL ACTION FILE NO.:
vs.	:	1:15-CV-00080-LJA
SPRING CREEK COOLER, INC.; SPRING CREEK PRODUCE, LLC; SF FARMS, INC.; SF EXPORTS, INC.; T & L FARMS, INC.; TERRIL SCOTT PROPERTIES, LLC; TERRIL SCOTT FARMS, LLC; WALDINE B. SCOTT FARMS, LLC; EDDIE T. SCOTT FARMS, LLC; T S EQUIPMENT LEASING, LLC; L & W FARMS, LP; TERRIL SCOTT; and JOHN DOE, Name Unknown, Address Unknown,	:	
Defendants	:	

VIDEOTAPE DEPOSITION OF PAUL W. HORCHOS, D.O.

Taken in the offices of
Northeastern Rehabilitation Associates, Morgan Medical Complex, 5 Morgan Highway, Suite 4, Scranton, Pennsylvania, on Wednesday, February 15, 2017, commencing at 4:22 p.m., before Steven R. Mack, Registered Merit Reporter, and Tim Art, Videographer.

GALLAGHER REPORTING & VIDEO, LLC
Mill Run Office Center
1275 Glenlivet Drive, Suite 100
Allentown, PA 18106
(610)439-0504 / (800)366-2980
GallagherReporting@Verizon.net

0002

APPEARANCES:

THE HELMS LAW FIRM
By: J. JEFFREY HELMS, JR., ESQ.
10 North College Street
Homerville, GA 31634
jeffhelms@helmslaw.com
-- For the Plaintiffs

GARDNER WILLIS SWEAT PLAIRE & PICKETT, LLP

By: MARK L. PICKETT, ESQ.
2408 Westgate Drive
Albany, GA 31707
mark.pickett@gwspplaw.com
-- For the Defendants

* * *

GALLAGHER REPORTING & VIDEO, LLC
Mill Run Office Center
1275 Glenlivet Drive, Suite 100
Allentown, PA 18106
(610)439-0504 / (800)366-2980
GallagherReporting@Verizon.net

0003

INDEX TO WITNESSES

INDEX TO EXHIBITS

INDEX TO OBJECTIONS

(Plaintiff Exhibit No. 1 was marked for identification.)

THE VIDEOGRAPHER: The date today is February 15, 2017, and the time is 4:22 p.m. This is the videotape deposition of Paul W. Horchos, D.O., taken in the matter of Michael Newcomb and Kathy Newcomb v. Spring Creek Cooler, Inc., et al., filed in the United States District Court, Middle District of Georgia, Albany Division, Case No. 1:15-CV-00080-LJA. This deposition is being held at Northeast Rehabilitation Associates, P.C., at 5 Morgan Highway in Scranton, Pennsylvania.

My name is Tim Art, and I am the videographer. I am with Gallagher Reporting & Video. The court reporter is Steve Mack.

At this time will counsel please state their appearances for the record, after which the court reporter may swear in the deponent.

MR. HELMS: Jeff Helms, and I represent Mr. and Ms. Newcomb.

MR. PICKETT: And I'm Mark Pickett, and I represent Spring Creek Cooler and the other defendants in this case.

* * *

PAUL W. HORCHOS, D.O., having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. HELMS:

Q. Doctor, good afternoon. How are you doing?

A. Good. Thank you.

Q. Good. We met earlier. I'm Jeff Helms, and I represent the Newcombs.

If you could, let's get started by you introducing yourself to the jury by telling them your full name, and tell us what you do for a profession.

A. My name is Paul William Horchos. I'm almost 50 years old. I've been in practice here at Northeast Rehabilitation doing physical medicine and rehabilitation for about the last 20 years. I work here seeing patients that have suffered from musculoskeletal injuries, neurological injuries, cerebral concussions, and traumatic brain injuries.

I have a full-time practice. I see about 25 patients a day. I have a hospital

practice that I maintain, and I go to the hospital in the morning to see rehabilitation patients as well.

Currently my practice is about 60

0006

to 70 percent traumatic brain injury or concussions. It's really blossomed over the course of the last five years, and that's -- that's when I decided to become board-certified in brain injury, and I was board-certified in brain injury medicine in 2014.

I work with several of the local high schools and colleges, helping them work out their concussion protocols and their return-to-play protocols. I do do assessments for the Veterans Association for blast injuries and traumatic brain injuries for them, helping to determine the nature of the injury and the severity of the injury.

What else would you like to know?

Q. That's -- that's interesting and good to know. I appreciate it. It's a mouthful.

I want to break that down just a little bit. You went to medical school, you got a license to practice medicine here in Pennsylvania?

A. Correct.

Q. And you've been practicing medicine in Pennsylvania for how long? Did you say 20 years?

A. Twenty years. Since 1997.

Q. You mentioned board certifications in certain specialties, and I want you to explain those to the jury about board certifications.

0007

I think the first is in physiatric medicine and rehabilitation medicine; is that right?

A. Right. Well, I mean getting -- getting board-certified means that you have to pass a test, and in all honesty, they're probably the hardest tests I've ever taken. So --

Q. Those are -- those are national tests that --

A. Correct.

Q. -- you have to take?

A. They're national tests that you have to go to a special testing center, and they put headphones on you and you have to sit in like a -- you know, in like a little cubicle all day long and take this test.

But -- so I took the board certification for physical medicine and rehabilitation once, passed it, and then ten years later I had to take it again, as that's part of the

rules. I took it again and I passed it. So I'm board-certified twice in -- in physical medicine and rehabilitation.

I'm board-certified in disability evaluating medicine, so I evaluate patients for disability claims as well. I was eval -- I was

0008

board-certified for that and then recertified.

And then, like I said, in 2014 I took the national board certification for traumatic brain injury, which consisted of traumatic brain injury certification for both physical medicine and rehabilitation and for neurology.

Q. And is that -- is that a subspecialty of the physical rehabilitation board certification?

A. Yes.

Q. And again is that a test that's administered nationwide to people who want to have a subspecialty in brain injury?

A. Correct. Oh, and I mean one thing that I did forget to mention is that, you know, I've always been interested in traumatic brain injury, and when I trained, I trained at Moss Rehabilitation Hospital in Philadelphia, which is one of the preeminent traumatic brain injury centers in the country, and that's where I had exposure to traumatic brain injuries and had become interested in that.

And -- and over the course of my practice I've tried to drive it more towards neurological rehabilitation, which is exactly what that is; and when I had the opportunity to take the

0009

board certification in 2014, I jumped at it.

Q. When you say neurological injuries, what all parts of the body are you talking about when you -- when somebody has a neurological injury?

A. Well, neurological injury meaning neurological rehabilitation, so rehabilitation of their brain, rehabilitation of their cognitive function, rehabilitation of their visual and vestibular function, that's what I'm talking about.

Q. You practice here in Scranton? Are we in Scranton; is that right?

A. Correct, Scranton, Pennsylvania.

Q. How many physicians practice with you here?

A. Twelve other physicians.

Q. And the name of your practice is Northeastern Rehabilitation Associates; is that

right?
A. That is correct.
Q. How about the hospitals that you have privileges with or work with in the area?
A. Well, I -- I have privileges with the three major hospitals here in Scranton. One is in the Geisinger network, the other two are independent. One is called Moses Taylor, the other

0010

is called Regional Hospital.
I run the rehabilitation inpatient unit at Regional Hospital, a 15-bed rehab unit. Those are -- those patients are under my -- under my care.
And I also do consults in the hospital. I do consults during the week, I do consults on the weekends at these various hospitals as -- as I'm called to do so. Geisinger CMC in particular is a trauma center, so I see traumatic brain injury patients that come in there acutely.
Q. Getting down to what we're going to talk about today, you've seen a gentleman by the name of Mr. Michael Newcomb?
A. Correct.
Q. How did he come about seeing you?
A. He was sent to see me by Attorney Don Ligorio.
Q. And the purpose of you seeing Mr. Newcomb was what? What was the purpose of that?
A. Attorney Don Ligorio wanted me to quantify exactly what was wrong with him, what his diagnoses were, and what I thought about his injuries.
Q. Okay. Is that called an independent

0011

medical examination?
A. Yes.
Q. And you're board-certified in order to do that?
A. Correct.
Q. You follow a certain type of methodology; is that right?
A. Correct.
Q. And to assess Mr. Newcomb to see whether or not he's had a brain injury did you follow a methodology and test him on that?
A. Yes.
Q. And is that methodology, has it been peer-reviewed?
A. Right. The methodology that I utilize

is a methodology that was developed at the University of Pittsburgh Medical Center in association with the Pittsburgh Steelers, so that's really where the -- where the impact test was invented. You may have heard of when people pass or fail a concussion test. That's called an impact test.

And so they invented that there, but they also invented management and treatment of cerebral concussions based upon that, that

0012

methodology, and I employ that during my evaluation here.

Q. And you employed that evaluation when you did the examination of Mr. Newcomb I take it?

A. Correct.

Q. Yeah. And that's a -- that's a scientifically medically-based methodology?

A. That's correct.

MR. PICKETT: Object to leading.

Q. Is that a scientifically med -- medicine-based methodology?

MR. PICKETT: Object to leading.

Q. That you could go ahead and answer.

A. Well, what I would say is I would say that there's been multiple peer-reviewed articles that have been published regarding the validity of these -- this testing and these train -- and these treatment methods which base -- are based upon what's called the VOMs, visual/ocular -- V-O-M? Visual-ocular motility testing.

And so it's basically looking at their balance and their visual function and how -- how that -- how they -- how they respond to provocation of those sorts of testing activities.

Q. If you could, and you got a report in

0013

front of you, and just walk through it as much as you need to -- or refer to it as you walk us through this, but just walk the jury through what you did to arrive -- or to carry out this examination of Mr. Newcomb. And you arrived at some opinions based on that examination, didn't you?

A. That's correct.

Q. All right. Just walk us through that if you could, what you do in the regular course when you're asked to evaluate somebody like Mr. Newcomb.

A. Well, Mr. Newcomb came into the office for this evaluation. I believe that some of the family members were with him. And I asked him

various questions about his -- his injury. I asked him about how it occurred, I asked him about what he experienced at the time of his injury.

I asked him what kind of treatment op -- what kind of treatment he went through, what kind of treatment was offered to him, what he -- what he decided to do, what he -- what he may have decided not to do with regards to his treatment, and what kind of ongoing symptoms he was suffering from at this point in time.

That was basically the line of my questioning, and --

0014

Q. You took a history from him I guess is what it's called?
A. Well, that's --
Q. Yeah.
A. -- that's what I'm saying, right.
Q. Yeah.
A. So that's the methodology though of what I've done.
Q. Yeah. How much time did you spend with Mr. Newcomb questioning him about what happened to him, what's been the effect of his injury?
A. About 40 minutes.
Q. And did you review medical records along with interviewing and examining Mr. Newcomb?
A. Yes.
Q. And how much time did you spend doing that?
A. About three hours.
Q. And the records that you reviewed that jump to your mind that were most important that helped you arrive at your opinions about Mr. Newcomb, which ones were those?
A. Well, I mean the problem -- the reason you might want -- the reason why it takes three hours to review is because you don't know what's on

0015

any one page, so you have to go through every single page.

You know, so I'm sitting at home and going through it, and my kids are like, "Dad, you're going to read that whole thing?" And I'm like, "Yeah." You got to.

You know, so if you're asking me what really stands out?
Q. Yes.
A. I suppose the imaging studies stand out to me, but -- but everything I think, you know, is

important to the story.
Q. Yeah. Let's go back and ask, what did Mr. Newcomb tell you about how he was injured?
A. Mr. Newcomb told me that he was on a loading bay. And the back of his truck I guess was up to the loading bay and he was standing there; and a forklift had a load on the forks, and I guess the operator didn't see him; and it swung, and as it swung around it caught Mr. Newcomb and threw him in the air; and unfortunately, he -- well, unfortunately or fortunately, he struck the corner of the back of his trailer, hitting his head on this hinge that was holding the -- the door to the back of the trailer.

0016

Q. Did you see a scar of where that had happened?
A. You can't miss it.
Q. Yeah.
A. So yes. The answer is yes.
Q. Okay. All right. What did he tell you about the -- how he felt afterwards that was important to helping you come to your opinions and based upon your -- that was part of your examination, the history of it, what did he describe to you about his physical condition that was important to you after the injury?
A. Well, when we -- when we look at people who may or may not have suffered from a concussion injury, you look for acute findings, and acute findings in this particular situation are dizziness and some disorientation, fatigue, sleepiness. Those kinds of things that he was complaining about are typical following a cerebral concussion or a brain injury.
Q. Those are consistent with somebody who's got -- suffered a brain injury?
A. Correct.
Q. Yeah. You knew that he eventually had surgery with Dr. Azeredo at Geisinger; is that

0017

right?
A. I do.
Q. Yeah. And you mentioned some of the, what you said, scans or radiology tests that were done --
A. Correct.
Q. -- on Mr. Newcomb. Can you tell us about those. Did you actually look at the films as they used to say themselves, or now they're

digitized on a computer --
A. Correct.
Q. -- plus read the reports?
A. Right, I looked at the disks and I read the reports.
Q. Okay. And what did the disks themselves, the films themselves reveal to you that you saw, that was important based upon your examination and opinions you reach?
A. Well, one -- one study that was important was the -- was the CT scan of his head that revealed that there was fluid in his left ear, a large amount of fluid in his left ear. And obviously that's not normal, and it went along with Mr. Newcomb's complaints that he was having a hearing impairment, progressive hearing loss.

0018

So cerebrospinal fluid, unlike other types of fluid, has glucose in it, so when you -- when they tapped it and looked at the fluid, they were able to identify that it in fact was cerebrospinal fluid or what we know as brain fluid.
So the fact that there was brain fluid inside of the ear on the inside part of the -- of the eardrum indicates that there was trauma and a rip inside of the brain to the dura.
So that -- that doesn't happen with insignificant trauma. That happens with a -- with a pretty solid force, so it tells you something about the amount of force that hit the patient, or that the patient experience -- that the patient's brain experienced.
The other study that is of importance in my opinion was the MRI scan that was done in 2014 of his brain, and that one showed that there was significant high-intensity abnormalities in the -- in the left parietotemporal region, and also showed that there was evidence of encephalomalacia. So encephalomalacia is --
Q. Now, those are some big words, so break those down for us if you could.
A. Yeah. So the high-intensity zones, what

0019

that basically means is it means that there's areas of inflammation in the brain. So just like if we took a scan of you ankle if you had sprained your ankle, you would see some increased inflammation there.
So there was areas of increased inflammation in the brain, which is not good.

Inflammation in the brain indicates that there's injury. And --
Q. Let me just stop you right there if I could. I want to ask you to look at Plaintiff's Exhibit No. 1 here that we looked at earlier.
A. Right.
Q. Just tell us before you show the jury --
MR. HELMS: That's right. We'll do --
MR. PICKETT: Just for the record, we -- we object to Plaintiff's --
MR. HELMS: Yeah.
MR. PICKETT: Is Plaintiff 1 is the exhibit?
MR. HELMS: That's right, yeah.
MR. PICKETT: Okay.
THE WITNESS: All right. So --

0020

BY MR. HELMS:
Q. Let -- let me just ask you a few questions.
A. Sure.
Q. What is this?
A. This is a picture of a brain.
Q. Okay. Is it a -- is it an accurate representation of the human brain?
A. Yes.
Q. Will this help you explain your testimony to the jury about the areas of Mr. Newcomb's brain that was injured?
A. I think it would help, yeah.
Q. Yeah. Okay. Okay.
A. All right. So this --
Q. The areas you were talking about that had the inflammation.
A. Well, I think first I have to orient --
Q. Yeah.
A. -- people a little bit.
Q. Please.
A. Okay. So this is a brain. Okay? This is the front of the brain, so your eyes would be right here. This would be the back of the brain. Okay? And this here would be the brainstem, and

0021

that turns into the spinal cord that goes down, down the -- down the spine into the back. Okay?
So the areas that I'm talking about is this area right here showed that there was injury. Okay, that's right over the ear, right

there.
And then the other place that we see some evidence of injury is -- let me see before -- I don't want to misspeak. And then the other place that we see it is in the temporal lobe, so down here, where we actually see this encephalomalacia.
So up here what you see is you see evidence of inflammation. Okay? Inflammation means swelling and injury to the brain. Now, that's not a good thing, and if you have inflammation in the brain, it causes dysfunction, it causes impairment of -- of thought. It can sometimes cause seizure disorder, those sorts of things.
Encephalomalacia is a large word, you're right, and what that basically means is it means area of brain that has been damaged and then subsequently just absorbed. Okay?
So what it really is, is it means kind of like a hole in the brain, and so down here

0022

you have some evidence of what we would call like Swiss-cheesing of the brain, so you have these little holes in the brain tissue. Okay? And what that means is it means that those areas where the Swiss cheese holes are is they -- it's dead brain tissue.
Q. And you could see that on the MRI?
A. Yes.
Q. Okay. All right. Jumping around just a little bit here, I see on your CV you're a consulting physician for Geisinger; is that right?
A. Correct.
Q. And what does that mean?
A. That means that if they want me to do a consult, I come down there and do it at the hospital. I did four of them this weekend.
Q. Have you been down to the hospital where Dr. Azeredo practices in Danville?
A. Thankfully, I've had no reason to go there, no.
Q. Okay.
A. Because that's about an hour and a half away.
Q. Okay. They have a clinic that's up here in Scranton?

0023

A. Right.
Q. Yes.
A. Right.

Q. Okay. Geisinger does, yes?
A. Yeah, Geisinger is a network of hospitals. They have, I don't know, maybe -- maybe ten hospitals in the area.
Q. It's a big operation, isn't it?
A. Correct. And that's sort of the -- that's sort of the mecca, if you will, in Danville. That's where it all started.
Q. You read the reports of Dr. Azeredo and Dr. Toms, the neurosurgeon, and if you could, just generally summarize and describe for the jury the type of surgery that Mr. Newcomb underwent.
A. Well, the brain is a delicate structure, and although it has its own built-in helmet, right? That's what our skull is. If the brain didn't have fluid around it, it would tend to bang into the skull, and that would be bad. So the cerebrospinal fluid, or CSF as it's known, is this fluid that -- that surrounds the brain, both on the sides and on the top and underneath, and it basically kind of creates a cushion for the brain inside of the skull.
And especially on the underside of

0024

the skull. The underside of the skull has sharp edges that kind of stick up in various locations, and so if the brain kind of rubs against those sharp edges, sometimes it can have injury.
And there was a structure there that was -- that was ripped, causing a tear in the -- in the dura; and the dura is the -- is the coating that keeps all that CSF in its proper location. And when that happened, it dripped out into the ear canal, and it was caught by the eardrum in the ear. So it would have been dripping out of his ear if there had been a hole in his eardrum, but as it was, it just kind of built up behind there, but it's not supposed to be there.
And so the surgery that -- that the doctors at Danville did is they repaired that leak. And that's very important, because if you have a leak like that persisting, it will cause significant damage to the brain, it will cause ongoing headaches.
Q. Now, in your report, if you'll look at that, you talk about symptomology? You have a whole section where you talk about symptomology.
A. Right.
Q. And describe that. What do you mean by

0025

that and -- and what were your findings under the

section of symptomology?
A. Well, I said to the patient, What do you suffer from; what makes you feel different from being normal? And he told me that -- that he suffers from a headache most of the time. He told me that he had been through a lot of treatments for the headache but hadn't gotten any better. He told me that he's very grouchy, used the words insufferable. He gets mad about stupid things, things that he thought that he never would get mad about before.
He doesn't like bright light. It's called photophobia.
Q. I was going to ask you about that. You used the word photophobia and phonophobia.
A. Right. Photophobia doesn't like bright light, so sometimes fluorescent lights can be bothersome. Headlights can certainly be bothersome, especially the modern newfangled ones that are so bright. And sun of course can be -- can be disturbing.
So it's a -- it's a phenomena that, you know, you might think might be able to be treated with -- with sunglasses or maybe with a hat,

0026

but it's funny. It's just -- it's an issue that -- that's difficult to treat, photophobia, and patients tend to just sort of change their lifestyle. They tend to stay in darker areas; they tend to not go out in order to prevent that from happening because they -- the phono -- photophobia gives them a headache and it makes them feel uncomfortable.
The same thing with phonophobia. It just basically means that patients don't like like loud noise or, you know, kids playing in the room, you know, anything like that. And that also was bothersome to him, and it was something that was never bothersome to him before.
He also has issues with regards to his visual function in the left eye. He has dizziness. And he sometimes gets nausea and actually throws up without any kind of provocation. In other words, he's not throwing up because he ate a bad clam or something like that; he just throws up because he just throws up.
Q. Is that a symptom of people who have brain injuries?
A. I have found that oftentimes it's a symptom that's associated with vestibular dysfunction or dizziness that goes along with the

0027

brain injury. So in other words, they -- they may not realize it, but something may drive their dizziness suddenly, and as a result of that they -- they feel nauseous and may sometimes throw up.

Q. I interrupted you there, but I just want to ask you about something. You have a section in your report, you talk about aggravating factors, on the next page.

A. Right.

Q. Where did these aggravating factors come from?

A. You mean in this patient's condition?

Q. How did you find out about these aggravating factors? Is this what he told you, or is this what his family told you or . . .

A. Yeah, I said -- I said, What -- what makes you unhappy or what makes you feel -- feel poorly; and he said that he doesn't feel well when he's with a lot of different people and he has to manage those situations. He told me that it makes him feel uncomfortable.

He doesn't like it when there's multiple conversations taking place, and multiple conversations could be, you know, like the dinner table where various people could be having

0028

conversations at the same time.

And you and I don't think about it all too much, but we're able to -- part of what's important about -- about our brains when they're healthy is that we're able to suppress information that we don't want to hear. So somebody else might be talking over there, and we're just trying not to pay attention to it.

Sometimes when you have a brain injury, it impairs that ability to suppress that other information, so when other people are talking around you, it keeps interrupting your own conversation; you can't ignore it.

Q. You talk about a family member or family members have attended the examination. Is that something that normally happens when you have somebody that has a brain injury, talk to the family members about how some --

A. It's very helpful.

Q. Yeah.

A. I mean oftentimes you ask questions that the fam -- that the patient themselves may not recall or may not be able to answer with, you know,

good confidence, so it gives you some corroboration.
Q. Now, in this case you looked at his past
0029
medical history. Based on the information you had available to you about his past medical history, did you see anything that was relevant or significant to you as it relates to the injury he suffered back in June of 2013?
A. No, I don't think so, but I mean -- but, you know, he's not a babe. I mean he's -- you know, he's had a few things wrong with him, you know, he's --
Q. He's been a working man, huh?
A. Yeah.
Q. Yeah.
A. Yeah. So I mean that's -- that was the only thing that I took away from it is that, you know, he -- he has got a few miles on him.
Q. Now, we talked about the medical record review that you did, the diagnostic reviews that you did. You did a couple of exams yourself, physical examinations or exams yourself about his eyesight and his hearing and his smell. Is this a good time to talk about those?
A. Yes, I think so.
Q. All right. Tell us what those exams were you did on each aspect of it and why it was important to you in the opinions that you've arrived
0030
at in this case.
A. Well, I'm interested in his visual function because the -- the visual connections are -- are extensive. And I'm going to use this picture again.
Q. Yes, please.
A. Is that okay?
Q. Yeah.
A. So if the eyes are up here, the part of the brain that actually processes visual information is all the way in the back. Okay. So this pink area back here called the occipital lobe is actually the area that -- that processes visual information. As a result of that, what it means is it means that there's a long nerve track, so the nerve has to go a long way to get all the way to the -- to the back of the brain. And so if you're going -- if you're going look for something on a physical examination that's going to inform you that -- that a portion of the brain may have been injured, it would be best to look at the nerve

tracks that travel the farthest distance through the brain, which is the reason why I looked at the eyes. Okay? And so the --

Q. What did you find?

A. So this -- the important thing to know about the eyes as it pertains to concussions or traumatic brain injuries is that we have two eyes and those two eyes have to work together, and that's something that in this patient was not happening.

So when we looked at his visual convergence, we found that his visual convergence was abnormal. So visual convergence means that as you look at an object far away, your eyes should be more or less parallel, but as an object comes in closer to you, your eyes should turn in; and on repeated trials this individual was not able to turn his eyes in, they were staying in a parallel position as he -- as they came in like this.

And his visual convergence was limited to 25 inches from the nose, which is very far. A normal convergence would be something like 1 inch from the nose.

Okay. So what that means is it means that anytime he was trying to look at something up close he -- he would struggle, and it would invariably intensify headache pains -- pains.

Q. Is that something that's consistent with somebody that's suffered a brain injury?

A. Yes.

Q. And yet using this diagram again, was the nerve track through the area that had the signs of injury on the MRI scan?

A. Right. So yeah --

Q. And could you show the jury where that was, please.

A. Yeah, those -- those nerve tracks would -- would run back through this area. So the -- the optic nerve comes in underneath here and then gets processed, and then they track along the side of the brain, like that, right through this area. It's called the optic radiations. And yeah, so there's an abnormality there.

So furthermore, looking at his eyes, I looked at his visual saccade functions. That means the ability of him to move his eyes quickly back and forth from side to side and up and down. He had impairment with regards to that.

The other thing that was important

to note was that he had what we call visual nystagmus with a type of testing called VOR or visual-ocular reflex.

And what that means is it means that there's communication between the eyes and the inner ear. The eyes and the inner ear have to be in

0033

constant communication because the inner ear is telling our brain what is the position of our head, and that's important for our eyes to know.

So when you turn your head from side to side, that information is being processed at the very same time that your visual information is being processed, and those two systems work together. When there's a disturbance, what happens is when you turn your head quickly the eye flickers back and forth, and that's called nystagmus, and this patient had presence of nystagmus.

And when that happens, at least in this particular examination, and quite frequently on other examinations, the patient experienced nausea and queasiness. So that goes along with what I had said earlier, that it tends to come with -- from dizziness that patients don't expect. So -- so we saw that.

Q. Let me just stop you right there just a second and ask you a question. In medicine you hear the terms used objective and subjective symptoms.

A. Right.

Q. Yeah. And were these -- just briefly define each one for the jury so they'll understand, we'll all understand. An objective symptom, what is

0034

that?

A. Objective sym -- you want me to tell you what objective symptoms are or what objective symptoms are in this case?

Q. Generally objective versus subjective, and then the objective symptoms you found with Mr. Newcomb.

A. Right. Okay. So -- so objective basically means things that are -- that are hard to -- hard to simulate or to pretend. Okay?

So in this individual, saccadic functions are something that are objective because you're seeing the eyes move in a -- in a pattern that is -- that is not possible to affect, especially when you're -- when you're seeing abnormalities in regards to the movement.

The same thing is true with the

visual convergence. The visual convergence, the eye will -- you'll have asymmetric movements of the eye. In other words, one eye will actually move instead of both eyes moving together. That -- I would defy anyone to try to move one eye at a time. It just doesn't happen. We move eyes together in a -- in a unified fashion.

So those are -- those are things

0035

that cannot be copied or simulated or pretended. Okay?

Q. The bottom line, in your opinion was Mr. Newcomb faking any of these symptoms?

A. No. I don't think it's possible to fake them. I guess that's what I'm trying to say in a --

Q. Yes.

A. -- roundabout way.

And then subjective. But subjective is important in this, too, because you see, a lot of times what happens is that patients will have movements or have activities that they become aware of that they make them feel sick, that makes them feel badly; and so what they'll do is they'll either move slowly or they'll avoid environments that put them in that sort of position.

And so when you're testing these things, you are trying to actually provoke some symptoms, so you're actually trying to make them feel sick. So when they tell you oh, yeah, that made me feel dizzy or oh, yeah, that made me feel nauseous, that's actually a positive response to the test. Okay?

Q. And that's consistent with what you would expect; is that right?

0036

A. Yeah.

Q. Yeah. Now, you've talked about a visual test. Tell us about, you did some tests about his ability to smell?

A. Correct.

Q. Yeah. And why is that important with somebody who's had a brain injury?

A. It's actually very important to look at the sense of smell because -- you know, you probably have heard people say, you know, that -- I don't know. Some percentage. Let's say, you know, 45 percent of our brain doesn't do anything. Well, that's not really true. Okay? But what they're referring to is they're referring to the frontal lobe.

The frontal lobe is the part of the brain that actually does all the things that are hard to quantify, the kind of things that make -- make a person, you know, the person that they are. They create your personality, they create your motivation, they -- they make you do the things that -- why you do them. Okay?

They make -- the frontal lobe doesn't control your arm, it doesn't control your leg, it doesn't control sneezing, but it does make

0037

your personality what your personality is.

And so it's hard to assess the frontal lobe, but underneath the frontal lobe, right here, is where the -- the olfactory lobes are, and that's the projections of the nerves that run out to your nose. And when you have an injury to the -- to the brain, if you have an injury to the frontal lobe, you'll often find abnormalities in the sense of smell.

And so with this patient, I tested him cinnamon, coffee, and smelling salts or ammonia; and he was unable to note the coffee or the -- or the cinnamon, and when I put the smelling salts under his nose -- and I mean I put it under my nose earlier before I examined him just to sort of remind myself how bad that smelled. And when I put it underneath his nose, he said, "Yeah, I smell that," but he didn't recoil. So I mean he didn't even have a normal reaction to that.

So that tells me that there's damage to the olfactory lobes, and that suggests to me that this is the etiology or the cause of his -- of his personality disorders and issues with regards to some of his anger management problems.

Q. Did you see anything in his medical

0038

background that might -- Mike could attribute the problems with his smell other than his head injury in this case?

A. Well, he was a truck driver for 30 years, and -- and he -- and he did some fabrication of sheet metal for a small time. I don't know. Maybe -- maybe if you were a lifetime welder, maybe, but it doesn't sound like he was.

Q. All right. So you carried out those tests. Hearing I think is another one you -- you did?

A. Yeah, he did have a reduction of hearing in his left ear, and he did also have tinnitus,

which is a buzzing in the ears; kind of persistent, it doesn't go away.
Q. And that is subjective, isn't it? There's no way you can test to see whether he really has tinnitus in his ear or not?
A. Correct. But he did have auditory testing that did indicate a reduction in his -- in his hearing functions.
Q. All right. You talk about his gait. What is gait?
A. It means how well he can walk.
Q. And did he have any issues with his --

0039

his ability to walk?
A. Well, he did -- he did in the sense that his balance was impaired.
Q. The balance. What about his brain injury would affect his ability to balance? Yeah, I think you talked about the eyes and the ears have to work in conjunction. Would that affect his ability to balance?
A. Well, it's not just about -- it's not just about the eyes and the ears working in conjunction, although that's part of it, but it's also -- it's mostly about the synchronization of those activities.

In other words, if -- if there's a disturbance in how long it takes that information to get to the brain and to be processed, then -- then if the inner ear is saying I'm moving to the left and the eyes -- but by the time that information gets there the eyes are already noticing that you're moving to the right, then the body gets confused, and it doesn't know which way to move in order to fix it.

So part of the problem is, is that the synchronization of information being processed by the brain gets delayed, so it's not getting there

0040

at the same time; and when it's not getting there at the same time, it would be like -- it would be like as if you were telling somebody how to drive but there was a two-second delay in telling them the directions about what you want them to do. While you're telling them to turn, and they would -- the turn would have already come. You follow me?
Q. Yes, sir.
A. So that's what drives the -- the impairment of the balance.
Q. And just real quickly. I know I guess

your major focus was on a possible brain injury, but you did what's called a range of motion and palpitation. If you could just briefly go over what you found on those.

A. Well, the issue with regards to that is our scalp is full of nerves, and there are nerves that run from the back of the head, and -- and the scalp is covered with muscles as well. The frontalis muscle is the muscle in the front of the forehead, the temporalis is on the side of the head; and you see commercials all the time on TV for -- for Botox treatments for -- for migraine headaches.

So the question is, is, you know, is the patient's scar on his -- on his forehead and

0041

his temporal region, that horseshoe-shaped scar that he has, did that cause injury to the muscles and maybe cause some scar tissue to the muscles themselves or maybe -- maybe catch or kink some of the nerves of the -- of the cutaneous structures of the -- of the scalp.

So that's why I was checking those areas out to see whether or not they were tender and trying to come to some understanding of whether or not Botox would be beneficial for him in regards to that.

Q. And what was your impression about that?

A. That he did have significant tenderness not only in his neck but also into his -- into his facial and scalp muscles, and that he had already had a couple of Botox injections done that were -- was questionable whether they were helpful or not.

Q. We've been over some of the neurological testing that you've done, so we'll pass through that.

You've got one -- before we get to your impressions on page 7, you talk about Waddell's testing. Describe for the jury what Waddell testing is.

A. Well, Waddell's testing is kind of where

0042

we try to trick the patient. We try to ask them to do different things in different ways that we've already asked them to do and to see whether or not they -- they can't do them, because they should be able to perform the same task in different ways.

So when I did that with him, there didn't seem to be any -- any gaming of the -- of the examination.

Q. Is that something you have to look for

in the line of your profession and people in rehabilitation and doing independent medical examinations, whether a person who claims they're injured, whether they're really injured or not?
A. Yeah, that's part of it.
Q. Yeah. Did you see any evidence at all that Mr. Newcomb was magnifying his symptoms or not being truthful with the problems he was complaining about?
A. No.
Q. All right. You -- you have a list of impressions here, and we've really covered a great deal of them, but I think what we want to get down to, in your opinion is Mr. Newcomb physically, given his injury, able to go back to work?
A. I don't think that he's going to be able

0043

to be gainfully employed.
Q. Okay. And why is that? What are the most limiting factors that he has given his injury?
A. Well, his -- his balance is certainly a risk. Falling is certainly something that he could do easily. His visual function is not normal, and his -- his visual function in his left eye is impaired. His visual convergence makes it difficult for him to see things up close. His photophobia makes it likely that he's going to have difficulty driving a truck or -- or managing the sunlight or headlights on a regular basis.
He -- he has a pissy personality at this point in time which makes it difficult for him to --
Q. That's a technical term; is that right? Yeah.
A. Well, I don't really quite know how to put it, but I mean --
Q. Yeah.
A. -- but, you know, he readily admits that things that shouldn't bother him do --
Q. Um-hum.
A. -- and he lashes out about it. So, you know, I wouldn't want this kind of person working as

0044

a customer service representative for me. If I had a company, I wouldn't know exactly how they were going to respond, and quite frankly, I don't think that Mr. Newcomb knows how he would respond. You know, he may go in to work every day and say now today I'm going to be good, but he seems like he sometimes has no control over it.

Q. And is that something you see on a consistent basis, for someone who has suffered a brain injury like Mr. Newcomb?
A. Yes. Yeah, that's very common. Dyscontrol, I mean that's the -- that's the term. The problem is, is that trying to control dyscontrol through the use of medications oftentimes results in further cognitive suppression. So --
Q. When you say cognitive, explain to us what you mean by that.
A. Well, so -- so if you're trying to control these episodes by giving him medications that -- that dampen his cogni -- his brain function. You know, if you lower the horsepower of his brain, well, then you're going to bring out other problems, like the fact that maybe his memory won't be so good, or maybe he won't be able to have the motivation to carry out a certain task or a certain

0045

activity.
So -- so episodic dyscontrol means this -- this loss of control, this anger, this irritability, that kind of thing. And there are medications that can be used to control it, but they oftentimes result in further loss of brain horsepower, which in this situation with his traumatic brain injuries you'd want to try to minimize.
Q. Speaking of medications, what kind of medications . . .
A. What kind of medications would you use?
Q. Was he using at the time when you saw him.
A. Oh. I believe he was using primarily pain medications. Oxycodone, which is a short-acting pain medication; OxyContin, which is a long-acting pain medication; and tizanidine, which is a muscle relaxer. Those are the primary medicines that he was taking for this condition. And --
Q. Was he taking some Lexapro at the time?
A. Lexapro as well, which is an antidepressant.
Q. Is that something that physicians

0046

usually give to somebody who's suffered a brain injury that affects their -- their mood?
A. Well, you might, but I don't -- I don't know if it would always work, but you could try it.
Q. All right. Going forward with

Mr. Newcomb, do you have an opinion within a reasonable degree of medical probability, medical certainty, is Mr. Newcomb going to get any better in the future, given his injury?
A. Oh, I certainly think that he could get better, but I don't think he could get back to the -- back to normal, not with the -- not with the damage and the injury that he has sustained so far.
But I certainly think that -- that there's a possibility that his headaches could be better controlled. I think that there's a possibility that his visual function could improve with the proper therapy. I certainly think that his balance could improve with the proper therapy as well.
But, you know, you need to apply this in the -- in the appropriate place, and you need to -- you need to gain his confidence so that he understands that the discomfort that he might be going through to attend the therapy may ultimately

0047

pay off in the end.
Q. As somebody who does an independent medical examination, you don't also treat a patient like Mr. Newcomb, do you?
A. I'm not treating Mr. Newcomb, no --
Q. Yeah.
A. -- but --
Q. He's not your patient in other words?
A. He's not my patient.
Q. Yeah. If you were able to tell the jury today what you thought would be good for Mr. Newcomb as far as rehabilitation goes, what would you have in mind for him?
A. Well, I think he needs to keep on trying with various medications to try to help improve his -- his -- his headache management. I think that that's one of the most important things. Dr. Kelley at Geisinger Danville had been working with him regarding that, and it was my understanding that they were going to continue to do the Botox injections.
I really think that trying to control the headaches are really the first step that you need to do to try to improve the patient's ability to tolerate any other activity; because

0048

right now I think the headaches really tend to drive a lot of his irritability, his symptomatology, and his -- and his desire to shut it down, which is what

he does most of the time.
Q. Um-hum.
A. So that's where I would focus initially.
Q. How about from a physical rehabilitation? Anything that you would have in mind that maybe would be of help to Mr. Newcomb?
A. He definitely needs to do a vestibular therapy program, and he definitely needs to do a visual therapy program. Those are two things that without a doubt would provide him with improvement in regards to his clinical evaluation based upon what I saw on his exam on this particular day.
Q. Vestibular? I ask you to explain that to us, please.
A. It means being able to understand and tolerate movement, that's what that means.
So believe it or not, watching a football game for an individual like this can -- can make a person feel dizzy, just moving their eyes back and forth watching the football move and the football players move on the screen, let alone, you know, actually trying to -- to do it himself.

0049

So vestibular therapy is -- is making a patient more comfortable observing movement and participating in movement. And again, that's -- that's something that we all take for granted. We take for granted that -- that -- that our ability to understand and tolerate movement is -- well, it's something that's innate.
But you have to remember that when we were babies we moved very slowly, and we kind of over time, you know, got used to going a little faster, a little faster, a little faster until we get to, you know, maturity, and -- and we forget about how we get there.
Q. I'm going to wrap it up here with you, Doctor. I'm looking on page 8 of your report, and you make a comment about the third paragraph down about his work capacity, and you said it's been reduced to zero. If you could just tell the jury, why did you make that statement?
A. Well, when I -- whenever I see a patient, if I see a patient who -- who let's say, for example, has a difficult time lifting, I think, well, can the patient sit down? Because if the patient could sit down, maybe they could work in a seated capacity.

0050

So with this individual,

Mr. Newcomb, I thought: Okay. Well, can the guy do physical activity? And then, you know, no, I don't think he can do physical activity because of his visual function, because of his balance function.

Can he do interpersonal activities? No, because his personality is impaired.

Can he do sedentary, you know, paperwork, sorting papers, so on and so forth? No, because of his visual impairment.

So I kind of was looking at trying to -- trying to run the gambit through my own head about how this guy could potentially get back to work, and at the end of the day I wasn't able to come up with something that seemed to be successful.

Q. In the line of your profession is that ultimately what you want to do for your patients is see that they're rehabilitated so they can get back to a normal lifestyle?

A. Well, absolutely.

Q. Yeah.

A. But as of the time that I evaluated the patient that was -- that was the status he was at. If I had -- if I had the ability to treat him, I

0051

would be doing different things and hopefully trying to move him towards one of those goals.

Q. And you saw him in April of 2015?

A. Correct.

MR. HELMS: Okay. Doctor, thank you very much. Mr. Pickett I'm sure will have some questions of you.

THE WITNESS: Okay. Thank you.

THE VIDEOGRAPHER: Your mike.

MR. PICKETT: Thank you.

* * *

CROSS EXAMINATION

BY MR. PICKETT:

Q. Dr. Horchos, you did not exactly treat this injury, but you did see the scar from where it occurred, correct?

A. Yes.

Q. And that scar was on the left side of his head?

A. Correct.

Q. And in fact with the -- the exhibit a few minutes ago that you were referring to, the diagram of the brain?

A. Yes.

Q. The way that's oriented, that would be

0052
the left side; is that right? Or am I wrong? Is that the right side?
A. Well, I guess -- I guess so. I mean --
Q. Could you hold it up, maybe make . . .
A. (Descriptive gesture)
Q. Okay. So that would be -- that's a side view of the brain, correct?
A. Correct.
Q. And that would be drawn from the -- showing the left side?
A. Correct.
Q. The right side would be a mirror image, but that one is actually the left side?
A. Yes.
Q. Okay. And you were able to see where his injury had occurred from the scar?
A. Right.
Q. Okay. Which was on the left side?
A. Correct.
Q. Now, you also reviewed the medical records, including the procedure that was done by Dr. Azeredo, and -- and some of the imaging records to also confirm that this injury was indeed on the left side?
A. The injury, you mean the brain injury?

0053
Q. Yes, sir.
A. Yes.
Q. I mean was there another injury that you looked at of him?
A. Well, I thought -- the scalp injury I thought you -- you know, I'm just differentiating between the scalp injury and the brain injury.
Q. Okay. Well, is it your opinion that the scalp injury is what caused this brain injury?
A. Well, the scalp injury is an external -- is an external injury, and the brain injury is an internal injury.
Q. Okay.
A. From the same mechanism.
Q. But you think they came from the same -- at the same time?
A. Yes.
Q. And they were both on the left-hand side?
A. Yes.
Q. As far as the -- there are two types of information you take, and some of that is in fact subjective that came from Mr. Newcomb, correct?

A. Correct.
Q. And some of the -- when you spoke with
0054
him, you spent about 40 minutes speaking with him?
A. Right. And then another 20 minutes to a half an hour examining him.
Q. Okay. During that 40 minutes that you examined him -- or spoke with him, interviewed him, you took some handwritten notes?
A. Yes, I did.
Q. And you have those with you?
A. Yes.
Q. Okay. One of the things that he told --
A. Would you like them?
Q. Pardon?
A. Would you like them?
Q. I have a copy.
A. You do?
Q. I just want to make sure that you had them so that --
A. Oh, okay.
Q. -- if I refer to something in them, you would be able to --
A. You got my scratch pad, huh?
Q. I do. I have all kinds of things.
A. All right.
Q. We get all the information we can to try to evaluate something.
0055
One of the things that he told you as you were evaluating him, he told you that in this accident he was thrown 10 to 15 feet?
A. Yes.
Q. Okay. And you don't know if that's true or not, do you?
A. I don't.
Q. But that's what he told you?
A. Yes.
Q. And you're sure -- you wrote that down, so you're sure that's what he said, it threw him 10 to 15 feet?
A. Yes.
Q. If it -- if it -- in fact he only fell a shorter distance or moved a shorter distance, maybe a few feet, then if he had actually moved a few feet and he told you 10 to 15 feet, then he exaggerated the accident, did he not?
A. Sure, I guess -- I guess that's possible, yeah.
Q. Well, I mean if he only moved a few feet

and he told you it was 10 or 15, then he exaggerated, didn't he?
A. I only know what -- I asked him what had happened, and that was pretty much what -- what he

0056

told me. So yeah, I guess the answer is yes.
Q. Okay. And you have to -- you have to rely on what he tells you as far as the subjective taking of a history from him, correct?
A. Right. But then, you know, then you read through, you know, the voluminous records and you try to corroborate it, but the problem is, is that sometimes the information gets corroborated by -- in other words, either true or false information can be corroborated, you know.
So, you know, the ambulance crew might come up to him or something like that and say hey, what happened? If the patient tells the ambulance crew that I got thrown 10 to 15 feet, then that gets put into the medical record and it gets perpetuated.
Q. Okay.
A. You know what I mean? So sometimes even when you look through the medical record if you find information like that, your point is well taken. Maybe -- maybe it's -- maybe it's just a repetition of that original exaggeration.
Q. Okay. Did he also tell you that he had a skull fracture?
A. The patient?

0057

Q. Yes, sir.
A. Well, no. My understanding was that he -- in Georgia he was not diagnosed with a skull fracture, but obviously he had a skull fracture if -- if brain fluid got into the area of the internal auditory canal.
Q. Okay. He had a -- well, he had a -- I believe you said he had a rupturing of the dura.
A. He did, but he also had -- had injury to the bone itself. That's -- that was my understanding from Azeredo.
Q. Okay. You believe there was actually a fracture to the bone itself, not just to the --
A. I believe so, yeah.
Q. -- to the dura?
A. But I mean the original CAT scan that was done in -- in Georgia did not show a fracture.
Q. Okay. If you'd look at your handwritten notes, the last page. Those are your -- those

handwritten notes are from your 40-minute interview with him, correct?
A. Correct.
Q. Not from your three-hour review of the medical records later on?
A. That's right.

Q. Okay. So from your 40 minutes with him, if you'd look at the last page of your written notes, you've got a notation, "had a skull fracture."
A. "Saw ENT, neurosurgery; had a skull fracture, CSF leak. Put in a plate, used ear tissue to close the area."
So this is -- this is -- this is verbal communication with the patient and his family.
Q. Okay. So in -- in your verbal communication with him, he indicated to you that he had a skull fracture?
A. Right.
Q. He also indicated to you that he had had a plate put in his head?
A. Correct.
Q. Okay. And you've reviewed Dr. Azeredo's operative notes?
A. Right.
Q. And he did not put a plate in his head, did he?
A. Well, I will say this though. I'm not a surgeon, and I would say that Dr. Azeredo's operative notes are very complicated.

Q. Okay.
A. And I read through them many times and tried to understand them as best as I could, and this is the -- I'm only -- I'm only a person.
Q. Okay.
A. This is the best I was able to do.
Q. Okay.
A. Okay? But I would say that the notes were -- that the operative notes were complicated.
Q. Okay. But just to establish, there are two things. One, Mr. Newcomb told you verbally that he had a plate in his head?
A. I guess so, yeah.
Q. Okay. As far as whether there actually was a plate put in his head by Dr. Azeredo, you'd have to defer to him to that -- on that one?
A. Yes.

Q. Okay. The -- aside from the subjective tests, you did some objective tests, too, correct?
A. Yeah.
Q. And one of -- one of those was the visual convergence test?
A. Yes.
Q. Now, do you know if he had ever been tested, his visual convergence had ever been tested

0060

before?
A. I don't think it ever had been.
Q. Okay. So if he'd had this as a -- as a birth defect from earlier in life and it just was the first time that you had tested it, there's no -- there's no way for you to know that, is there?
A. I -- I think that it's the kind of deficit that you can't function with without some sort of modification. I mean if he -- if he had this deficit from -- from birth, he would have had, you know, glasses that look like Joe Paterno's, you know what I mean? Thick, thick glasses to be able to control that.
Q. Okay. So --
A. Because I don't see how he would have gotten through grade school.
Q. Can the visual convergence be corrected with corrective lenses?
A. It can be, yes.
Q. Okay. So could his, the one that he displayed for you, could it be corrected with visual -- I mean with corrective lenses?
A. Well, like I'm saying, you know, you -- if your convergence is 25 inches from your nose, everything you're reading would have to be like

0061

this, (descriptive gesture) you'd have to be holding it at arm's length.
Q. Okay.
A. So what I'm saying is that you're asking me, you know, do I think that that finding is a real finding, do I think that that finding is an objective new finding, and my answer is yes, I think that it is; because the patient to my recollection wasn't wearing, you know, thick, you know, soda-bottom glasses.
Q. He would need something like reading glasses like I'm using right now?
A. Thick ones.
Q. Okay. A very strong reading glass?
A. Yes, sir.

Q. Could his visual convergence that he displayed for you, could it be corrected with corrective lenses, with glasses?
A. It could be, but you'd have to -- you'd have to turn them -- you'd have to put them on and take them off and put them on and take them off. You wouldn't be able to have bifocals that would be able to make that kind of correction.
Q. Okay. You would have to put them on when you're reading something within 25 inches from

0062

your face?
A. Yeah. I mean I have had patients that have had some visual correction lenses for -- for visual convergence abnormalities, but they don't really work that well because they don't work well when you look to the side, they only work well when you look right straight ahead. Because when you look to the side, your eyes now are not converging at the same point, so the left eye has a longer track than the -- or the right eye has a longer track than the left eye.
So in other words, these glasses are -- are of -- are of impaired util -- you know, mild utility because of the fact that you can only look straight ahead with them.
Q. Okay. Of course when you're reading something within 25 inches of your face, you're going to be looking straight ahead when you're reading, correct?
A. Yeah.
Q. Okay. The nystagmus test that you gave him. Now, other things can affect nystagmus as well, can they not?
A. Like drugs?
Q. Yeah.

0063

A. Yes.
Q. Drugs can affect it, right?
A. Yes.
Q. Opioids could -- or would be a particular drug which could affect it?
A. Well, opioids, perhaps if you -- if you were naive to opioids. That is, if you had never taken them before and you took a dose, you might see something like that, but I don't think that you would see chronic nystagmus with regards to the use of chronic opioids. I've never seen that before, and I don't believe that that's -- would be a typical finding.

Q. But opioids can cause the nystagmus that you saw?
A. As I said, to opioid-naive patients, meaning people that have not taken them chronically.
Q. Okay. And he you would not describe as opioid-naive?
A. No.
Q. He was very experienced when it comes to opioids?
A. Well, he's -- his body has become tolerant to them.
Q. Okay. In fact -- I mean as far as

0064

opioids go and his experience with them, you've reviewed some of his medical history?
A. Yes, I did.
Q. And are you aware that in his medical history he's been taking various opioids since back in 2004?
A. I don't know how long he's been taking them for.
Q. Okay.
A. So if that's what you say, then I'll accept that.
Q. That wasn't something that he told you about or that you determined during your examination of him?
A. I guess, you know -- again, you know, it's -- it's a limited examination, but I mean I didn't ask him, you know, for how long have you been taking these medications. But I do know that -- that the headache doctor, Dr. Kelley, did try to withdraw him off of those medications, and it didn't go very well.
So at least at this point in time he's at -- he's taking the -- the narcotic pain medications at least to some degree to control his headaches as well.

0065

Q. Okay. Dr. Kelley's treatment of him, she was trying to determine whether his -- he was suffering from a medication overuse headache syndrome?
A. Right.
Q. She believed that his headaches may be caused by his overuse of narcotics?
A. Right.
Q. And she tried to take him off of them and it did not go well?
A. Well, I made mention in my -- in my --

in my report here that -- that she even tried to use what's called a bridging technique, which is a pretty complicated technique. So basically trying to control inflammation with the use of prednisone while trying to taper the patient off of those medications.

So she -- she followed the book, you know, to try to accomplish that, but it didn't seem to work.

Q. Okay. The narcotics can -- could be the cause of his headaches?

A. Well, are you asking me or are you telling me?

Q. Well, I'm -- Dr. Kelley had that

0066

opinion, did she not?

A. Well, I made -- I made comment again that it -- that may or may not have been true; that's what I said in my note. And the only way that you would know is if you try to withdraw them, and you see if the patient . . .

Most of the times that I've ever taken care of patients that have had medication overuse syndrome, you have to have a long discussion with them and you really have to educate them about what it is that might be happening, and then you have to ask them, please, could you please try to reduce these medications for two days, and we'll see what happens. And if you gained their confidence, most times the patients will do that.

And the times that I've been right and the patient has had medication overuse headache, they come in and say, Doctor, you were right. When I stopped doing that, I felt so much better. It almost -- that that's the way it goes.

Q. Um-hum.

A. Okay? So if that's what Dr. Kelley did, which I think she probably did, and -- and the patient didn't come back and say that, then -- then it wasn't medication overuse headache.

0067

So that's -- that's my answer -- that's my long-winded answer to your short question.

Q. Okay. The -- and the truth is you don't know what Dr. Kelley did or didn't do in that regard, do you?

A. Well, I know what I wrote. I -- I know that she considered . . . the most important thing about medication overuse headache is that you consider it, that you consider it. Okay? And if

you consider it, then -- then you usually evaluate that and determine whether or not the patient's behavior is consistent with that.
Q. Okay. Well, can we agree on this, that the --
A. That the doctor did consis -- consider it.
Q. The doctor did consider it and that the -- that medication overuse could be the reason for his headaches?
MR. HELMS: I object to the form.
A. Well, she -- she explored that, and it didn't seem -- it didn't seem to make any difference whether -- whether he stopped the medication or not in regards to the headaches. In other words, the headaches didn't get any better, which would suggest
0068
that it wasn't.
Q. Okay. But again, overuse of medication, an overuse of narcotics could cause headaches?
A. True. But an overuse of other medications, such as Motrin or Tylenol, could also cause headaches.
Q. Okay. The overuse of narcotics could cause dizziness?
A. Again, there's a lot of evidence that supports that patients that are tolerant of narcotics don't suffer from dizziness, don't suffer from vestibular abnormalities, but acute -- acute high doses of narcotics in individuals who are unused to them? Certainly it could cause dizziness.
Q. It could cause blurriness of their vision?
A. Yes.
Q. In taking a history from Mr. Newcomb, did he -- did he tell you or not tell you that he had been involved in a motor vehicle accident back in 2004 in which he received an injury to his -- the left side of his head and to his left eye?
A. No, he did not tell me that.
Q. Would that -- because we're looking at injuries to the left side of his head, would that be
0069
important for you to know and to consider in giving your opinions?
A. Well, everything is -- more information is always better than less.
Q. One of your opinions is that he cannot return to being a commercial truck driver, correct?
A. That's my opinion.

Q. He can't drive?
A. I don't think he can drive safely, no.
Q. Not a commercial truck or not a car?
A. I don't think so.
Q. Okay. If he -- approximately six months after he saw you if he drove from here in Pennsylvania to South Georgia, which is a very long drive, would it surprise you that he was able to drive that far?
A. If he drove from Pennsylvania to South Georgia?
Q. Yes, sir.
A. Yeah, I'd be a little surprised.
Q. Given his -- his dizziness and his nausea and his vision and his hearing, that would make it difficult for him to drive from Pennsylvania to South Georgia?
A. I wouldn't be surprised if it made it

0070

difficult, yeah.
Q. Okay. And if he were to be driving -- or traveling from Pennsylvania to South Georgia -- you met his wife, and the rest of his family, too, correct?
A. Right.
Q. His wife seemed able-bodied to you?
A. I think so, yeah.
Q. Any reason that you know why she would not be able to make that drive; if the two of them were in the car together that she would not be the one behind the wheel?
A. I have no idea why.
Q. Okay. You were hired in this case to give an independent medical opinion.
A. Right.
Q. Have you -- did you -- are you aware that a Dr. Rajjoub also prepared an independent medical examination?
A. No.
Q. So you have not been able to review his report?
A. No.
Q. Would that be helpful or beneficial to you in reaching your opinions?

0071

A. Well, like I said, you know, more information is better; but in the world of legal stuff I've kind of stopped asking why I'm given some things and not given other things, so I just review what's given to me.

Q. And who was it that -- that hired you to perform this IME?
A. Attorney Donald Ligorio.
Q. And who did he represent?
A. The patient.
Q. Mr. Newcomb?
A. Right.
Q. Okay. Were you aware that a Dr. Bennett had also done an independent medical examina -- examination?
A. Only because counsel told me that -- that Dr. Bennett did an IME, I don't know, however long we've been here, an hour and a half ago.
Q. Okay. So I take it you haven't had an opportunity to review his report either?
A. No.
Q. Okay. And again, the more information being the better, it would be helpful if you had been given the opportunity to review Dr. Bennett's report as well?

0072

A. What? You mean -- you mean in preparation of this -- in preparation for this deposition?
Q. That, and also in making your opinions about Mr. Newcomb's conditions.
A. Well, I don't think that that -- was that deposition available at the time that I saw him? I don't know.
Q. No, Dr. Bennett's was done after. But as far as your testimony today and your continued opinions about Mr. Newcomb --
A. Yeah, I mean I would -- I always prefer to answer questions about things that I know about. Fair enough?
Q. Fair enough.
A. Okay.
Q. And at no time have you been Mr. Newcomb's treating physician?
A. No.
Q. You were just asked to give opinions about legal matters?
A. Correct.
Q. And as far as today, who -- who hired you to be here for today?
A. Counsel.

0073

Q. Okay. And counsel, you're talking about Mr. -- Mr. Newcomb's attorney in this case?
A. Correct.

Q. And he is paying you for being here today?
A. That's correct.
Q. And paying you for -- did he pay you for the initial IME?
A. No.
Q. How much were you paid by Mr. Newcomb's first attorney for the initial IME?
A. I think $1500.
Q. Okay. And how much are you being paid to appear today to give this testimony?
A. Well, a video deposition is more expensive. I hate to sound like an idiot, but, you know, I don't exactly know. I think it's . . . $3500.
MR. HELMS: That's right.
A. $3500.
Q. Okay. And Mr. Newcomb's attorney is paying you to be here to give that opinion --
A. Well --
Q. -- $3500, correct?
A. No. Mr. Newcomb's attorney has paid me

0074

to come in here and answer questions that are being asked about the case.
Q. Okay. And he's paid you $3500 for that?
A. He has paid me $3500 to sit here for an hour and a half and get grilled, correct.
Q. Okay. That is all the questions I -- oh, one last question.
Again, the injury to Mr. Newcomb that you observed the scars on and for which you reviewed the records was on the left side of his head?
A. Correct.
MR. PICKETT: That's all I have. Thank you.

* * *

REDIRECT EXAMINATION

BY MR. HELMS:
Q. A couple follow-up questions, Doctor.
Obviously Mr. Newcomb is not a medical doctor himself; is that right?
A. Correct.
Q. So when he was explaining to you what Dr. Azeredo did, he was just telling you based on what he understands as a layperson happened; is that right?

0075

A. Well, I mean that's so true.

Q. Yeah.
A. I mean I had a patient once that came in and told me that he had his fish gill removed from his neck, a fish gill. And what was amazing about that was that he just said it like that and went on to the next subject; and I kind of was thinking, what the heck is a fish gill?
But he -- in other words, the point is he didn't care what it was; he just was happy that it was taken out.
Q. Yeah.
A. So yeah.
Q. And you've read the operative report that Dr. Azeredo did to fix the leak, didn't you?
A. Yes.
Q. Yeah. On a scale of 1 to 10, how serious was that surgery?
A. Well, like I described it, it's very complex, very complicated. In fact it took two surgeons, didn't it?
Q. Yes.
A. Yes, it took two surgeons.
MR. PICKETT: I'm going to object to counsel answering the question.

0076

A. Well, I know it took two surgeons.
Q. Yeah.
A. There was an ENT surgeon and there was a brain surgeon involved in it. So that's a lot of surgery for a very small area.
Q. Any time you operate on the brain, that's a pretty delicate matter, isn't it?
A. I would say so.
Q. Yeah. Is a tegmen, have you heard that? That bone in the inner ear or inside the skull?
A. I'm not really familiar with that, with that term as a bone, but -- because some of the bones have different names.
Q. Yeah.
A. You could call something the occipital bone, you could call it the basilar bone. So I'm not really sure what bone they're referring to.
Q. Yeah. But you read in the operative report whether or not that bone was actually broken, fractured?
A. Yeah, and I don't have the operative report --
Q. Yeah.
A. -- in front of me. If somebody wanted to provide me, I could -- I could, you know, dissect

0077
that a little bit more. But from what I read, the important point was is that there was fluid that was getting into the inner ear canal, which comes through a crack in the bone, and there was a tear of the dura that was frayed. Frayed, f-r-a-y-e-d.
Q. Somebody who had a visual convergence I think you said of what? Twenty-five inches; is that right?
A. Yes.
Q. Could somebody like that be driving an 18-wheeler tractor-trailer up and down the road with a -- with just a pair of corrective glasses --
A. No.
Q. -- backing it up?
A. No.
Q. Okay. They physically wouldn't be able to do that in your opinion?
A. It would be impossible.
Q. Yeah. Is that -- if Mr. Newcomb had been driving an 18-wheeler for 30 years before this incident right here, would that seem to indicate to you that he didn't have this visual convergence before this incident?
A. It would be highly unlikely that --
Q. Yeah.

0078
A. -- he would have this abnormality.
Q. Right.
Now, there was also a lot of questions about, well, Mr. Newcomb, did you fly through the air, go through the air 3 feet, 4 feet, 11 feet, 15 feet?
What did you understand that Mr. Newcomb's head struck when he did get hit and his head hit something as a result of this forklift hitting him? What did you understand his head struck?
A. Mr. Newcomb's head struck the -- the reinforced rear entry to the trailer. And I --
Q. Is that significant to you?
A. Yeah, that is significant.
Q. Why is that?
A. Well, it's significant because in my experience I have seen bad concussions and bad traumatic brain injuries when -- when patients hit the doorframes of doors, and -- and I have come to believe that the reason why that is is because the doorframes are reinforced, and doorframes when they're reinforced recoil less to their hit.

So in other words, what takes the hit is the head and the brain, not the -- not the --

not the door or not the object that they're hitting. And so in this -- in this truck the door is attached to this -- to the side of the -- of the trailer, and that side of the trailer at that point, in that location is reinforced so that the door doesn't -- doesn't move up and down or wiggle. And so where he hit I believe was reinforced and very sturdy, and I think that that impacted upon the severity of his injury.

Q. Yeah. Have you seen that in the course of your practice treating people with brain injuries, that somebody that hits their head on a doorframe suffers a more serious head injury?

A. Yes, I have.

Q. So in the -- at the end of the day whether he flew through 15 feet or 3 feet or 4 feet or 6 feet doesn't matter to you just as far as your diagnosis --

MR. PICKETT: Objection, leading.

Q. -- and opinions.

A. Can I answer?

Q. Yes.

A. Well, your point is -- is very well taken. The importance of -- well, what's important in a concussion is not acceleration; it's

deceleration, it's how quickly you decelerate. So when he strikes this object, (descriptive gesture) he decelerates very, very quickly, and that's what imparts the force on the brain.

Q. You read Dr. Kelley's reports from Geisinger. She was a neurologist I think?

A. Yes.

Q. Yeah. And based on what you know about protocols for trying to help somebody who's suffering from headaches due to narcotics, in your opinion, based on what you discussed with Mr. Newcomb also, were the narcotics causing his continuous headaches in this case?

A. It was my impression that they weren't causing his headaches. The intensity of the headaches seemed to be of such a degree that -- that he didn't think that he could tolerate being off of the pain medications.

Q. And is that the accepted protocol to follow in a situation like that, to wean him off narcotics to see if the -- they're causing

headaches?
A. Yeah.
MR. PICKETT: Object to the leading.

Q. Yeah, you can go ahead and answer.
A. I try not to put patients on narcotics, but the truth of the matter is, is that I do have some headache patients that are on narcotics, and sometimes that's all -- the only thing that will work.
Q. A couple more questions. We talked about this, an injury he had to his head back in 2004. It was actually to his forehead and had some stitches in there.
Assuming that this resolved, he had some dizziness or headaches from that particular injury and it resolved within a period of less than six months, is that significant to you in your formulation of your opinions in this particular case, an injury that occurred back in 2004?
A. Well, it's significant in the sense that it occurred nine years ago. So experience of multiple concussions is not good. If the guy did suffer from a concussion at that point in time, that could be harmful.
But what we do know about concussions is that it's not necessarily the number of concussions that you suffer, it's the fre -- it's the rapidity with which you suffer them. In other words, if you suffered three concussions over ten years, that's significantly better than if you suffered from three concussions over a one -- one football season. Okay? So -- so when you have those concussions that occur quickly without allowing the brain to fully recover, that's where you get cumulative trauma.
So in answer to your question, I think that if he had -- even if he had suffered a concussion in 2006 was it?
Q. Four.
A. Four. I'm sorry, 2004. Even if he had suffered that, it appeared as though he had recovered and had no additional sequelae or side effects from that.
Q. Would you assume if he was an over-the-road 18-wheeler truck driver for that period between 2004 until the time he suffered this injury, in your opinion would he have recovered from

that, whatever happened to him when he got hit in the head back in 2004?
A. Yes.
MR. PICKETT: Objection to leading.
Q. Okay. A couple more questions and we'll be gone. In your opinion are the narcotics causing him his dizziness?
A. No.
Q. Are the narcotics causing him his blurred vision?
A. No. Well, I mean in answer to that.
Q. Yeah.
A. His blurred vision, he has blurred vision in his left eye; so it would be real hard to have the narcotics cause unilateral blurry vision.
Q. You were asked about the opinions of two doctors who were, by the way, hired by opposing counsel in the earlier case to form opinions; and you haven't had a chance to review those reports, but does --
MR. PICKETT: I'm going to object to the facts not in evidence.
MR. HELMS: Okay.
MR. PICKETT: I'll let you finish the question before I object any more.
MR. HELMS: Yeah, I think . . .
BY MR. HELMS:
Q. Nevertheless, whatever those two doctors had to say, does that in any way change your ultimate opinions based on your review of the records, your examination of Mr. Newcomb, and your training and education as a rehabilitation specialist?
A. No.
MR. PICKETT: I'm going to object to leading as well.
Q. Do those -- do those opinions -- and let me ask it again to try to assuage my opposing counsel's heartburn on this question.
The opposing counsel asked you about a couple of opinions by other doctors who did their evaluation of Mr. Newcomb; is that right? You remember that?
A. Right.
Q. Yeah. You haven't had a chance to review those records?
A. Well, you keep saying like I haven't had

a chance.
Q. Yeah.
A. Nobody gave them to me.
Q. I -- granted, granted. They were not provided to you; is that right?
A. Correct.
Q. Got it. But -- and again in the long run as -- as you speak to this jury, what those

0085

records say, does that in any way change your opinions that you've written in your report and the opinions you've given here today?
A. I'm going to give you the same answer I gave --
Q. Yeah.
A. -- the other attorney, which is that I don't like answering questions about things that I don't know about.
Q. Um-hum.
A. But my humble experience with regards to traumatic brain injuries, and I've seen a lot of traumatic brain injuries that have been pooh-poohed, if that's a medical term, by other doctors, and when I've read their other reports, I haven't seen them perform the same examinations that I've performed.
Q. Yeah.
A. And so they come to conclusions oftentimes with -- with data that I believe is incomplete, because I don't believe that the physical examination tests the same things that I'm looking at.
Q. So it could be possible these doctors didn't do any of the tests that you've been trained to do as a specialist in this field?

0086

A. Well, it's possible --
MR. PICKETT: Object to leading.
A. -- and that's what I've seen --
Q. Yeah.
A. -- in other cases.
MR. HELMS: Okay. Doctor, I've grilled you enough today I think. Mr. Pickett might have some follow-up questions for you.
* * *
RECROSS EXAMINATION
BY MR. PICKETT:
Q. I have just a couple.
A. Okay.
Q. You've referenced a couple of times sports concussions, which we all heard -- all heard

a lot about lately. There was a movie about it that came out a couple years ago. It's a -- it's a big topic.

With those sports concussions, the problem is again not enough time to heal in between them; is that -- that's generally the problem?

A. That's one of the problems, abso --

Q. Okay.

A. Yeah, absolutely.

Q. All right. That presupposes that there

0087

is a healing that occurs after a concussion.

A. Correct.

Q. Is -- when we talk about traumatic brain injuries, the word "traumatic" in that sense is that there was some trauma, some physical impact with the head that caused the injury, correct?

A. Yes.

Q. It doesn't have to do with how severe the brain injury was or how permanent it may be?

A. You mean the term "TBI"?

Q. Yes, sir.

A. So concussion equals MTBI or mild traumatic brain injury. So correct. The -- I think we could argue that this patient didn't suffer an MTBI, he suffered a moderate traumatic brain injury.

Q. Okay. More -- more -- a more severe concussion?

A. More severe than just a -- than just a concussion --

Q. Okay.

A. -- yeah.

Q. And the mechanism by which he encountered that would be important for you to understand in determining if it was mild or moderate, the amount of impact that he had?

0088

A. I've -- I've always believed that that's true, yes.

Q. And we talked about how doorframes don't bend and metal bends even less, and if he flew through the air 10 to 15 feet, he would have a more significant impact than if he simply slipped and fell and hit his head, correct?

A. You would think it would take more force to throw someone through the air, sure.

Q. Okay. So you would think that the amount of force that his head suffered would be greater in that circumstance, correct?

A. Possibly, but -- possibly but not -- but

I can tell you that I can't say for sure. Because we -- we have done lots of research looking at -- at -- you know, you've heard I'm sure about football and, you know, they want to put little lights on helmets that -- that will blink if a person has sustained a -- a certain G force.
Q. Um-hum.
A. Okay? Well, the -- the threshold at this point in time that we think is necessary to sustain a concussion injury is 60 Gs. But if you look at the data, you know, on people who have helmets that get hit and they suffer a concussion,

0089

unfortunately it makes a difference whether or not the blow is linear, in other words straight on or straight to the side, or whether there's a rotatory component, and -- and those things confound it.
So it makes it hard to say, you know, specifically that, you know, X force equals concussion, because it has a lot to do with the trajectory, it has a lot to do with the rotation, it has to do with how the brain is rotating inside of the skull. So those -- those factors are as of yet unknown.
Q. Would you expect that someone who slipped -- I'll strike that question.
Overall with concussions and traumatic brain injuries, those are injuries to the brain that were caused by some trauma, some impact that the head suffered? That's what we're talking about as far as traumatic, correct?
A. Yes, but that's -- if you look at the CDC's definition of -- of concussion or mild traumatic brain injury, they state in the CDC -- at the CDC website they state that -- that a concussion can occur with a blow to the body.
Q. Okay.
A. All right? So you don't necessarily

0090

have to hit the head.
Q. Okay. But there's some impact that the body or the head has suffered, and that's -- when we talk about traumatic, that's the traumas that we're talking about?
A. Yes.
Q. Okay. And those injuries are expected the brain will heal over time?
A. Yes.
Q. Okay. And so in an injury like Mr. Newcomb has, it's one that we would expect would

heal over time?
A. That's true, but -- but the issue with regards to functional recovery may have less to do with healing and it may have more to do with rehabilitation.
In other words, perhaps the nerves are healed, but the nerves are untrained. And that's what I was saying to you that -- you know, that we take it for granted our abilities to do the different things that we do because we perfected them when we were babies.
And so in this individual, he may be able to -- to show significant improvement if he was able to participate in the appropriate training

0091

programs to help reactivate those neural -- those neural circuits.
Q. And that would be physical therapy essentially?
A. Physical therapy, balance therapy, vestibular therapy, and visual therapy as I've mentioned, yes.
Q. And do you know if he's participated in any of those sort of things?
A. I don't think he has.
Q. Okay. Final thing. You said that if he had had visual convergence, it would make it unlikely he would be able to operate an eight -- to drive an 18-wheeler?
A. Uh, yes.
Q. Okay. Is there anything different about him being able to drive a car with visual convergence as opposed to an 18-wheeler?
A. No.
Q. He wouldn't be able to operate either one of them?
A. I agree.
MR. PICKETT: Okay. That's all I have.

* * *

0092

REDIRECT EXAMINATION

BY MR. HELMS:
Q. You've had patients who drive against doctor's orders; is that right?
A. Patients do whatever they want.
Q. Yeah. Given Mr. Newcomb and based on your discussions with him and evaluation as a person, did he seem pretty headstrong type kind of guy?

A. Yeah, he did.
Q. In your opinion -- and you talked about the Waddell's test. Did you come to the conclusion or the opinion that Mr. Newcomb is a man who would rather be at work than be disabled?
MR. PICKETT: Objection to leading.
Q. What is your opinion about Mr. Newcomb's, based on your examination and review of him and that?
A. I think that -- I think that Mr. Newcomb's family wished that he would go to work.
Q. Yeah.
A. That's what I think. I think that he's a bear, that's -- that's what I think, and I think

0093

that they wish he had somewhere that he could ex -- you know, kind of release his -- his frustration.
Q. Himself did he relate to you that he would prefer to return to work as opposed to being disabled?
A. Absolutely.
MR. HELMS: Yeah. All right. Thank you, Doctor. Okay.
THE VIDEOGRAPHER: The time is 5:49. That concludes this video deposition.

0094

_____, 2017

I hereby certify that the evidence

and proceedings are contained fully and accurately in the notes taken by me of the testimony of the within witness who was duly sworn by me, and that this is a correct transcript of the same.

_____

Steven R. Mack
Registered Merit Reporter
Certified Realtime Reporter
Notary Public